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# Acute and non-acute markers of sexual offense. A comparison study

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# Acute and non-acute markers of sexual offense. A comparison study

**Mestrado Integrado em Medicina**

**Área: Medicina Legal**

**Trabalho efetuado sob a Orientação de:**
**Doutora Teresa Magalhães**
**E sob a Coorientação de:**
**Mestre Patrícia Jardim**

**Trabalho organizado de acordo com as normas da revista:**
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FMUP FACULDADE DE MEDICINA UNIVERSIDADE DO PORTO
UNIDADE CURRICULAR PROJETO DE OPÇÃO DISSERTAÇÃO / MONOGRAFIA

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## ABSTRACT

Sexual aggression is a worldwide problem, affecting children of all ages, socioeconomic levels, and cultural backgrounds, with serious bio-psychosocial consequences.

This study aims to contribute to an earlier detection and prevention of children sexual aggression (CSA), through the characterization of its recent and non-recent markers, from a forensic point-of-view.

For this purpose, a retrospective study was conducted, through the analysis of forensic medical reports of the alleged victims as well as the corresponding judicial outcomes, from 2004 to 2012 (n=372).

Results evidenced that recent CSA is more associated with single sexual contacts, perpetrated by strangers, characterized by more physical and sexual violence, suggestive or nonspecific injuries, the presence of heterologous male profile, with higher rates of diagnostic and suggestive forensic medical examination (FME) conclusions. Non-recent CSA is associated with more regular sexual contact, perpetrated by familial aggressors, characterized by less physical and more psychological violence, absent injuries, forensic psychological assessments, with higher rates of nonspecific FME conclusions.

In conclusion, health professionals must be aware of this problem to early detect and refer cases to forensic services, to improve better treatment and protection of the victims, as well as allow an effective prosecution in court.



## KEYWORDS

Children sexual aggression; Forensic medical examination; Judicial outcome


## INTRODUCTION

Children sexual aggression (CSA) is a worldwide problem of epidemic proportions, affecting children of all ages, socioeconomic levels, and cultural backgrounds, with a myriad of bio-psychosocial effects on victims/survivors, their families and on the wider community [1,2]. Indeed, survivors of CSA suffer the consequences of the aggression for a lifetime, with profound effects on physical and psychological health [1]. Globally, the CSA has been identified in percentages ranging from 7-36% in girls and 3-29% in boys, although females have a two or threefold risk, compared to males, to be sexually offended during childhood, and about one in ten women has been confronted with this experience [3,4].

About 90% of CSA are committed by men and in 70-90% of these, the perpetrator is known to the child. CSA affects approximately 12% of girls younger than 14 years old, and in 30-50% of these cases, the perpetrators are family members [2,4].

According to the World Health Organization, "child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual aggression is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person." Sexual activity may include rubbing, fondling, oral-genital contact, genital or anal penetration, exhibitionism, voyeurism, and exposure to pornography, among others [5].

It is important to distinguish two groups of individuals: the recently sexually aggressed and the non-recently sexually aggressed. Recent sexual aggression is most frequently related to isolated episodes, perpetrated by strangers and mostly associated with physical violence and can be considered as acute if the victim presents him/herself to forensic medical examination (FME) in the first 72 hours after the last sexual contact. On the other hand, non-recent sexual aggression is primarily related to long lasting sexual contact, perpetrated by a family member, or a non-family member known to the victim, usually characterized by less physical and more psychological violence and frequently reported much later after the last sexual contact, being considered as chronic. [6].

Diagnosing CSA is a challenge because many children cannot or do not want to report it timely. As a result, injuries and physical or biological evidence are not usually found. In recent CSA cases, due to the victim's age and type of sexual contact, most cases will show absence of injuries and evidence [4]. Usually, if sexual contact

is reported in the first 72 hours, it is more likely to find injuries and positive physical and biological evidence during FME, thus helping to prove sexual contact and sometimes providing the identification of the aggressor, allowing therefore an effective prosecution in court. This diagnosis is however affected by the child's age, sex and stage of sexual development [7].
To improve new approaches for early detection, diagnosis, treatment and prevention, it is extremely relevant to analyze the differences between recent and non-recent sexual aggression [8,9] .
The main goals of FME are to maximize the ability to collect and preserve evidence for potential use in the judicial system, to identify injuries and minimize the physical and psychological trauma [4].
The diagnosis of CSA is essentially based on the history obtained from the child (which should be performed by forensic interviewers) along with physical examination (including evidence collection, photo documentation and other samples collection for screening) [7]. Guidelines from the American Academy of Pediatrics recommend considering forensic evidence collection for up to 72 hours after the alleged sexual contact (in cases of ejaculation in vaginal vault), as injuries may rapidly disappear and as DNA destruction or contamination can occur through several mechanisms and victim's daily actions [10,11]. Collecting evidence beyond the 72 hour limit may yield positive results, and may be considered in specific cases, depending on the location or type of sample collected [11].
The aim of this study is to better characterize the recent and non-recent CSA, to improve their early detection and diagnosis, as well as identifying better methods for treatment and protection of the victim.

## MATERIAL AND METHODS

A retrospective study was performed based on the analysis of FME reports and corresponding judicial outcomes, related to complaints of victims under 18 years old, who were suspected of being sexually aggressed. These victims were evaluated by the forensic medical north services of the National Institute of Legal Medicine and Forensic Sciences of Portugal (INMLCF), from 2004 to 2012. Only cases until 2012 were included in order to provide time for judicial outcomes, representing 372 forensic reports and 372 judicial decisions made available by the Public Prosecutor Office and Courts. A specifically customized data collection form was always used and applied by two physicians, who were previously trained, to guarantee data repeatability and reproducibility. Data aimed to characterize the victim, their family context, the alleged aggressor, the alleged aggression, the forensic medical conclusions, and the judicial outcome. For cases involving multiple abusive sexual practices, only the most physically intrusive sexual practice was considered. The classification of the evidence in diagnostic, suggestive and unspecific was made according to the Guidelines for Medical Care of Children Evaluated for Suspected Sexual Abuse [12]. Due to the retrospective nature of the study, it was not possible to collect all data regarding all different variables. The statistical study consisted in the comparison between recent CSA ($\leq$ 72 hours between the last sexual contact and FME) and non-recent CSA (> 72 hours between the last sexual contact and FME).
The database was built using the EXCEL 2010 spreadsheet software, and the statistical analysis was carried out using PASW18 for Windows. Descriptive statistics were calculated. The chi-square ($\chi 2$) test was applied, when comparing categorical variables to verify the dependency and the existence of relations between the variables. For the numerical type variables, the Student's t-test was used. A level of significance of 0.05 was considered.

## RESULTS

This investigation considered 372 cases, corresponding to 17.9% of all suspected sexual aggressions against children reported to the forensic medical north services of the INMLCF of Portugal during the 9 studied years.
With the available data in the forensic and judicial outcomes, the study revealed the following results:

### 1. Characterization of the alleged victim

The majority of the alleged victims were female (78.0%). The average age for both sexes at the time of FME was 10.1 years (min=0.4; max=18.0; SD=4.3). Concerning their occupational activity, 75.8% were students, 24.2% of the victims were either too young to be in school, or unemployed, or employed at the time of aggression. As far as the type of family is concerned, most victims lived in a nuclear family (36.0%). Institutionalization was described in 5.7% of the cases.

The comparison between recent and non-recent CSA was not statistically significant regarding the sex, age and occupational activity of the alleged victim (Table 1). Analyzing the type of family of the alleged victims, the difference between recent and non-recent CSA was statistically significant, showing a higher incidence of nuclear families in recent CSA cases and a higher incidence of recombined, extended or institutionalized/foster family in non-recent CSA cases (Table 1).

**2. Characterization of the alleged aggressor**

The majority of the alleged aggressors were males (90.3%). Most aggressors were between 18-30 years old (15.9%). In most cases, the aggression was perpetrated in an intra-familial setting (48.1%), while 43.6% of all suspected cases were extra-familial (aggressors known or unknown to the victim). The perpetrator was the father or stepfather in 30.7% of all cases.
The comparison between recent and non-recent CSA was not statistically significant regarding the sex, age and occupational activity of the alleged aggressor (Table 2). Concerning the relationship with the victim, the difference between recent and non-recent CSA was statistically significant, showing a higher incidence of strange aggressors in recent CSA cases and a higher incidence of familial aggressors in non-recent CSA cases (Table 2).

**3. Characterization of the alleged aggression**

Considering the frequency of aggression, 36.8% of the cases were reported as a single event; in 19.6% the victims were aggressed sporadically and in 8.6% the aggression occurred regularly. Sexual practices consisted mostly in vaginal, anal and/or oral penetration (36.6%); attempted penetration was described in (7.5%) of the cases, fondling and/or contact between genitals in (29.1%). Regarding the place of the aggression, 58.3% took place in the victim's and/or aggressor's home. The circumstances of the consisted in 10.8% of verbal offenses, 14.8% of physical violence and 19.9% of weapon threatening, allurement or consent.
The comparison between recent and non-recent CSA was not statistically significant regarding sexual practices and place of the alleged aggression (Table 3). In terms of frequency and circumstances of the alleged aggression, the difference between recent and non-recent CSA was statistically significant, showing a higher incidence of single events and mostly associated with physical violence and other circumstances (weapon threatening/grooming or consent) events in recent CSA cases and a higher incidence of sporadically and regular sexual contact, in the victim's and/or aggressor's home and mostly associated with verbal offenses in non recent CSA cases (Table 3).

**4. Characterization of the first suspicion of the alleged aggression**

The first suspicion was mostly raised by relatives in 38.2%, usually parents. The most commonly described motive that lead to suspicion was the history revealed by the child (41.1%), physical or biological signs suggestive of aggression (14.5%) and eye witness (11.3%). The health units were the main place where cases were first assisted and identified (23.9%), followed by the police (14.0%) and child protection services (9.4%).
The comparison between recent and non-recent CSA was not statistically significant regarding the first suspicion of the alleged aggression (Table 4). As far as the motive that lead to suspicion and the first assistance of the alleged aggression, the difference between recent and non-recent CSA was statistically significant, showing a higher incidence of physical or biological signs suggestive of aggression, witnessed events and mostly associated with health units and police assistance in recent CSA cases (Table 4).

**5. Characterization of the forensic medical examination**

Regarding the time elapsed between the alleged sexual contact and the FME, the results were coded in 2 categories: less than 72 hours (22.6%) and more than 72 hours (54.8%). The cases in which there was no information concerning this aspect (22.6%) were, for statistical convenience, included in the latter group. In 65.1% of the cases there was no physical injury reported, 16.4% had nonspecific injuries and 18.6% had injuries suggestive of sexual contact. 2 cases resulted in pregnancy.
Biological evidence for DNA studies were positive and revealed a heterologous male profile in 3.2% and negative in 10.5%.

Toxicological studies were performed in 1.3% and microbiological studies in 6.2%, with negative results for all cases.
Forensic psychological assessment was performed in 64.8% of the cases.
The results of findings of CSA were unspecific in 79.8% of the cases, suggestive in 16.9% and diagnostic in 3.2%.
The statistical difference between recent and non-recent CSA was not tested regarding toxicological and microbiological studies, due to the reduced sample size of performed cases (Table 5). Concerning the injuries, genetic studies, forensic psychological assessment and findings in the FME, the difference between recent and non-recent CSA was statistically significant, showing a higher incidence of suggestive and nonspecific injuries, presence of an heterologous male genetic profile and diagnostic findings in recent CSA cases and a higher incidence of absent injuries, forensic psychological assessment and unspecific findings in non-recent CSA cases (Table 5).

### 6. Characterization of forensic medical examination conclusions

Taking into account the description of the alleged aggression and the results of the FME, conclusions were nonspecific for the diagnosis of CSA in 84.7% of the cases, suggestive in 12.1% and diagnostic in 3.2%.
The statistical difference between recent and non-recent CSA was statistically significant, showing a higher incidence of diagnostic and suggestive FME conclusions in recent CSA cases and a higher incidence of nonspecific FME conclusions in non-recent CSA cases (Table 6).

### 7. Characterization of judicial outcome

In 372 judicial outcomes provided by the Public Prosecutor Office, 69.1% were filed due to absent proof (26.9%) or insufficient proof (65.8%); 1.1% were temporary suspended, 1.9% dropped complaint. The remaining 28.0% cases faced prosecution in Criminal Court. The majority was convicted (80.8%) facing incarceration (40.5%), suspended sentence (53.6%) or security measures (6.0%), and 19.2% were acquitted. The average time between the time of FME and the time of the final judicial outcome was 15 months (Graph 1).
The statistical difference between recent and non recent CSA was not statistically significant regarding the judicial outcome of the alleged aggression (Table 7).

## DISCUSSION

Establishing the differences between CSA reported in the first 72 hours and after 72 hours of the last sexual contact (recent and non-recent CSA) is extremely relevant for both forensic and legal terms as well as preventive and early detection interventions. CSA is very frequent and has serious consequences, but still being a taboo, the lack of information and data makes it difficult to deal with the issue, specifically in Portugal.
According to the literature [2-4], our study revealed that victims of CSA were mainly females, younger than 12 years old and that the majority of the alleged aggressors were males, usually family members. As in other studies [2], our study showed that most of the time, FME was performed after 72 hours post assault (77.4%) and revealed no physical injuries and unspecific findings, neither confirming nor discounting a child's clear disclosure of sexual aggression.
Statistically significant differences between recent and non-recent CSA were found regarding to the type of family of the alleged victim, the relationship between the alleged aggressor and victim, the frequency of the alleged aggression, the circumstances of the alleged aggression, the motive that lead to suspicion of the alleged aggression, the first assistance place to the victim after the alleged aggression, the physical injuries at FME, the genetic study at FME, the forensic psychological assessment at FME, the findings of the alleged aggression and the FME conclusions of the alleged aggression, which is according to the characteristics of recent and non-recent CSA cases described in literature.
Recent CSA cases were related to: (a) nuclear family; (b) strange aggressors; (c) single events; (d) physical violence, weapon threatening, grooming and consent; (e) physical or biologic signs suggestive of aggression and witnessed events; (f) first health units and police assistance; (g) suggestive and nonspecific injuries; (h) presence of heterologous male profile; (i) diagnostic CSA findings; (j) diagnostic and suggestive FME conclusions.
Non recent CSA cases were related to: (a) recombined, extended or institutionalized/foster families; (b) familial aggressors; (c) sporadically and regular sexual contact; (d) verbal offenses; (e) absent injuries; (f) forensic psychological assessment; (g) unspecific CSA findings; (h) nonspecific FME conclusions.

Nuclear families are usually more cohesive, involving great care and support, allowing early reports of CSA and early FME. On the other hand, dysfunctional families tend to lack the attention and assistance needed in these cases to report them as soon as possible [13,14].

Literature reports that recent CSA cases are usually perpetrated by strangers to the victim, mostly in a single event, where the offender shows a very aggressive behavior towards the victim. The involvement is non-familial and the aggressor usually makes use of weapons, physical violence and grooming in order to control the victim and achieve his goals [9,14]. Moreover, studies report that in non-recent CSA cases, usually there is a higher level of emotional and coercive involvement between the aggressor and the victim, which creates a long lasting and secretive setting, contributing to regular sexual contact and later exposure of the case [2,4,9,13,15].

Recent CSA is usually involved in more intrusive and violent sexual practices, resulting in more injuries and physical or biological signs suggestive of aggression. This allows an early detection by the first suspicion (usually the parents) and first assistance in health units (usually hospital). In Portugal, it is by law, mandatory for any public sector employee to report every CSA suspicion to the Public Prosecutor (through the Police or the Legal Medicine Services) as it is considered a public crime. In opposition, non-recent CSA is usually associated with more verbal threats and less physical/sexual violence, allowing a lower visibility of the cases [9,13,15].

Previous studies [9,13,15] reported that as recent CSA involves more intrusive and violent practices, it is associated with a higher incidence of suggestive injuries; unlike non recent CSA, that is much more related to absent injuries at FME. In non-recent CSA cases, the possibility of proving the offense is compromised not only by the delay in conducting the examination, but also by the fact that non recent CSA tends to be physically less intrusive and presents lack of injuries and physical signs [2,6,9]. Literature refers that a normal genital examination at FME does not exclude the possibility of an occurred aggression, as usually, the absence of acute injuries is due to the nature of the non-invasive physical contact (touching, fondling, oral-genital contact), the stretching nature of the tissues without being injured after penetration, and the delay between the last sexual contact and FME that allows the healing of injuries [6,9,15].

In our study, the genetic study was performed in recent CSA, as recommended in previous studies, due to the fact that these cases present more intrusive sexual practices and an early FME (<72 hours post assault) [10,11]. As most of the time the reports occurred > 72 hours post assault (77.4%), in our study, only 11.6% performed genetic study. In 12 cases, a different genetic profile from the victim's one was found, mostly it was identified on the victim's body, which has a higher predictive value than the victim's clothes. However, it is important to emphasize that the absence of DNA evidence does not exclude the aggression, as it may be a result of delayed presentation to the FME, or a consequence of the type of sexual practice itself, usually related to non-recent CSA [9,15].

Forensic psychological assessment is extremely relevant in non-recent CSA cases, as the lack of evidence or genetic results does not exclude sexual aggression [16]. In these cases, the diagnosis of CSA should be based on the history told by the victim and on a forensic psychological and social examination of the caregivers, the aggressor and the family [7,10,16]. At least in non-recent CSA, there must be a systematic forensic psychological examination of the child to evaluate both the verbal and non-verbal information, as well as the validity of the testimony, which also counts as valuable evidence in court. However, the validation of the victim's testimony is only reliable if the child's information is spontaneous and uncontaminated [16].

Guidelines [12] were used to classify the CSA findings. Only pregnancy and identification of sperm in specimen taken directly from a child's body were considered as diagnostic findings. In our study, there were 2 cases of pregnant children and 10 cases of identification of heterologous male profile on the victim's body, totalizing 12 diagnostic findings.

After physical examination, laboratory studies and psychological investigation, it is important to reach a conclusion that combines all the parts of the FME [7]. As recent CSA is associated with more physical/sexual violence, more physical or biological signs suggestive of aggression, suggestive injuries, presence of heterologous male profile, diagnostic CSA findings, it is usually expected to be related to diagnostic and suggestive conclusions, unlike non recent CSA that usually presents nonspecific conclusions, due to the lack of evidence, absent injuries and nonspecific CSA findings [9, 15].

Previous studies [6] showed that convictions in CSA happened most frequently when FME conclusions are diagnostic or suggestive of CSA. This requires that FME must be performed by forensic professionals, specialized in the area of forensic sexology. A FME performed by an inexperienced medical expert in forensic practice may undermine the entire judicial process [17].

Our study revealed that 69.09% of the 372 judicial outcomes provided by the Public Prosecutor Office were filed due to absent proof or insufficient proof in 92.61%. Literature is in accordance with these results, reporting that the majority of CSA cases are filed as a result of little evidence [15,18].

Although there were 10 positive results for heterologous male profile in genetic studies and 2 pregnant children, considered diagnostic findings by the guidelines [12], only 7 of them resulted in conviction. This may be explained by the fact that the aggressor is less than 16 years-old, which, by the Portuguese law, is not subject to

prosecution; the circumstances of the aggression (consent of the sexual offense of a victim capable of judgment); and the insufficiency of evidence considered by the court.
Most cases that faced prosecution in Criminal Court (27.96%) were convicted, the majority facing suspended sentence, results according to published literature [6].

## CONCLUSION

FME especially in the first 72 hours post assault may be an essential tool for the evaluation and diagnosis of CSA. It is highly important to understand the differences between recent and non-recent CSA, to know the reality of CSA and improve new interventions towards greater prevention and early diagnosis. In our study, results highlight some particular characteristics that contribute to the seriousness of these cases:
The results of CSA cases characterized in this study are consistent with published national and foreign literature.
Our study revealed statistically significant differences between recent and non-recent CSA, regarding to the type of family of the alleged victim, the relationship between the alleged aggressor and victim, the frequency of the alleged aggression, the circumstances of the alleged aggression, the motive that lead to suspicion of the alleged aggression, the first assistance place to the victim after the alleged aggression, the physical injuries at FME, the genetic study at FME, the forensic psychological assessment at FME, the CSA findings and the FME conclusions of the alleged aggression, which is according to the characteristics of recent and non-recent CSA cases described in literature.
Despite increasing recognition of CSA, there is still a community taboo to disclosure these cases. CSA is a very disturbing topic, with serious consequences for all the victims, aggressors and corresponding families, but poorly studied, specifically in Portugal. Protecting children from sexual offenses is a primary goal. It is important to underline that CSA reports in the first 72 hours, are most likely to present injuries and positive physical and biological findings during FME, proving sexual contact and allowing an effective prosecution in court. Further prospective studies are needed, to achieve new detection, diagnosing and preventing methods.

## CONFLICT OF INTEREST

The authors declare no conflict of interests related to this study.

## ETHICAL STANDARDS

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). Informed consent was obtained from all patients for being included in the study.

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**TABLES AND GRAPHS**

**Table 1. Characterization of the alleged victim (n=372)**

| | | ≤72h (n=84) n (%) | >72h (n=288) n (%) | ρ |
|---|---|---|---|---|
| **Sex** | Female | 70 (83.3) | 220 (76.4) | 0.231 |
| | Male | 14 (16.7) | 68 (23.6) | |
| **Age (years)** | Average | 9.6 | 10.3 | 0.25 |
| | Min. | 1.6 | 0.4 | |
| | Max. | 17.1 | 18.0 | |
| | SD | 4.5 | 4.2 | |
| **Occupational activity** | None | 17 (20.2) | 49 (17.0) | 0.74 |
| | Student | 61 (72.6) | 221 (76.7) | |
| | Other/No information | 6 (7.1) | 18 (6.3) | |
| **Type of family** | Nuclear | 40 (47.6) | 94 (32.6) | 0.008 |
| | Monoparental | 16 (19.1) | 56 (19.4) | |
| | Recombined | 4 (4.8) | 34 (11.8) | |
| | Extended | 4 (4.8) | 41 (14.2) | |
| | Institutionalization/Foster family | 2 (2.4) | 19 (6.6) | |
| | No information | 18 (21.4) | 44 (15.3) | |

**Table 2. Characterization of the alleged aggressor (n=372)**

| | | ≤72h (n=84) n (%) | >72h (n=288) n (%) | ρ |
|---|---|---|---|---|
| **Sex** | Male | 76 (90.5) | 260 (90.3) | 0.157 |
| | Female | 2 (2.4) | 1 (0.4) | |
| | No information | 6 (7.1) | 27 (9.4) | |
| **Age (years)** | 13-17 | 6 (7.1) | 20 (6.9) | 0.75 |
| | 18-30 | 15 (17.9) | 44 (15.3) | |
| | 31-40 | 13 (15.5) | 39 (13.5) | |
| | 41-50 | 3 (3.6) | 22 (7.6) | |
| | >50 | 4 (4.8) | 25 (8.7) | |
| | No information | 43 (51.2) | 138 (47.9) | |
| **Occupational Activity** | Job | 16 (19.1) | 52 (18.1) | 0.25 |
| | Student | 7 (8.3) | 11 (3.8) | |
| | Unemployed/Retired | 6 (7.1) | 27 (9.4) | |
| | No information | 55 (65.5) | 198 (68.8) | |
| **Relationship with the victim** | Stranger | 9 (10.7) | 7 (2.4) | 0.004 |
| | Known to the victim | 37 (44.1) | 109 (37.9) | |
| | Familial | 32 (38.1) | 147 (51.0) | |
| | No information | 6 (7.1) | 25 (8.7) | |

**Table 3. Characterization of the alleged aggression (n=372)**

| | | ≤72h (n=84) n (%) | >72h (n=288) n (%) | ρ |
|---|---|---|---|---|
| **Sexual practices** | Fondling/Contact between genitals | 29 (34.5) | 79 (27.4) | 0.71 |
| | Attempted penetration | 8 (9.5) | 20 (6.9) | |
| | Oral penetration | 2 (2.4) | 5 (1.7) | |
| | Anal penetration | 9 (10.7) | 28 (9.7) | |
| | Vaginal penetration | 13 (15.5) | 57 (19.8) | |
| | Vaginal and/or anal and/or oral penetration | 6 (7.1) | 16 (5.6) | |
| | No information | 17 (20.2) | 83 (28.8) | |
| **Place** | Victim's and/or aggressor's home | 55 (65.5) | 162 (56.3) | 0.127 |
| | Other | 25 (29.8) | 80 (27.8) | |
| | No information | 4 (4.8) | 46 (16.0) | |
| **Frequency** | Single event | 50 (59.5) | 87 (30.2) | <0.001 |
| | Sporadically | 8 (9.5) | 65 (22.6) | |
| | Regularly | 4 (4.8) | 28 (9.7) | |
| | No information | 22 (26.2) | 108 (37.5) | |
| **Circumstances** | Verbal offenses | 3 (3.6) | 37 (12.9) | 0.035 |
| | Physical violence | 18 (21.4) | 37 (12.9) | |
| | Others | 21 (25.0) | 53 (18.4) | |
| | No information | 42 (50.0) | 161 (55.9) | |

**Table 4. Characterization of the first suspicion (n=372)**

| | | ≤72h (n=84) n (%) | >72h (n=288) n (%) | ρ |
|---|---|---|---|---|
| **First suspicion** | Relatives | 37 (44.1) | 105 (36.5) | 0.1 |
| | Other people | 14 (16.7) | 81 (28.1) | |
| | No information | 33 (39.3) | 102 (35.4) | |
| **Motive for suspicion** | Physical or biological signs | 16 (19.1) | 38 (13.2) | 0.008 |
| | History revealed by the child | 34 (40.5) | 119 (41.3) | |
| | Eye witness | 16 (19.1) | 26 (9.0) | |
| | No information | 18 (21.4) | 105 (36.5) | |
| **First assistance place** | Health units | 35 (41.7) | 54 (18.8) | <0.001 |
| | Police | 15 (17.9) | 37 (12.9) | |
| | Protection services | 6 (7.1) | 29 (10.1) | |
| | Others | 2 (2.4) | 6 (2.1) | |
| | No information | 26 (31.0) | 162 (56.3) | |

**Table 5. Characterization of the forensic medical examination (n=372)**

| | | ≤72h (n=84) n (%) | >72h (n=288) n (%) | ρ |
|---|---|---|---|---|
| **Injuries** | Suggestive | 22 (26.19)* | 47 (16.32) | 0.002 |
| | Nonspecific | 21 (25.0) | 40 (13.9) | |
| | No injuries | 41 (48.8) | 201 (69.8) | |
| **Genetic studies** | Positive | 12 (14.3) | 0 (0.0) | < 0.001 |
| | Negative | 31 (36.9) | 8 (2.8) | |
| | Not performed | 41 (48.8) | 280 (97.2) | |
| **Toxicological studies** | Requested | 4 (4.8) | 1 (0.4) | |
| | Not requested | 80 (95.2) | 287 (99.7) | |
| **Microbiological studies** | Requested | 7 (8.3) | 16 (5.6) | |
| | Not requested | 77 (91.7) | 272 (94.4) | |
| **Forensic psychological Assessment** | Requested | 43 (51.2) | 198 (68.8) | 0.003 |
| | Not requested | 41 (48.8) | 90 (31.3) | |
| **Findings** | Diagnostic | 10 (11.4) | 2 (0.7) | <0.001 |
| | Suggestive | 18 (21.4) | 45 (15.6) | |
| | Unspecific | 56 (66.7) | 241 (83.7) | |

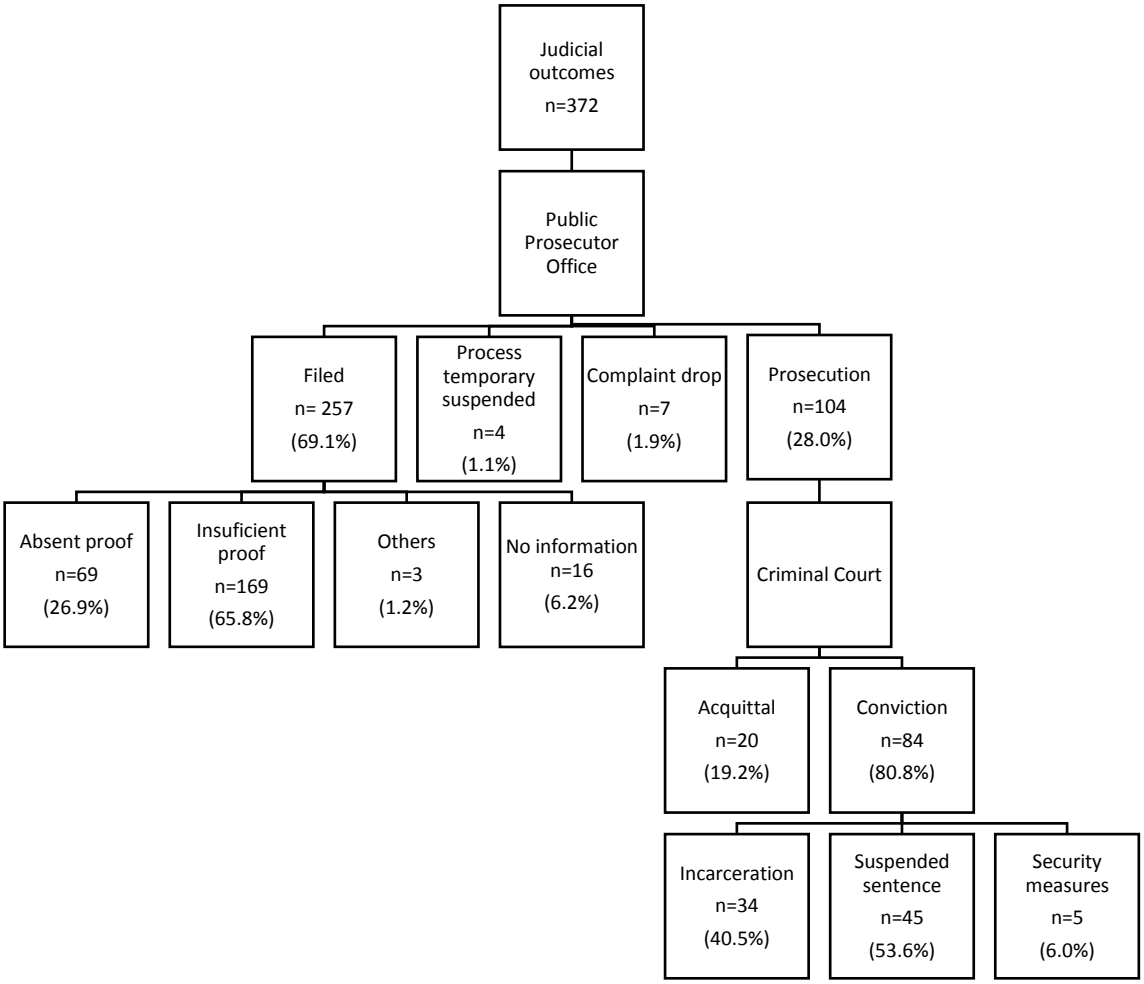
**Table 6. Characterization of forensic medical examination conclusions (n=372)**

| | ≤72h (n=84) n (%) | >72h (n=288) n (%) | ρ |
|---|---|---|---|
| **Diagnostic** | 9 (10.7) | 3 (1.0) | <0.001 |
| **Suggestive** | 12 (14.3) | 33 (11.5) | |
| **Nonspecific** | 63 (75.0) | 252 (87.5) | |

**Table 7. Characterization of judicial outcome (n=372)**

| | ≤72h (n=84) n (%) | >72h (n=288) n (%) | ρ |
|---|---|---|---|
| **Conviction** | 20 (23.8%) | 64 (22.2%) | 0.76 |
| **Non conviction** | 64 (76.2%) | 224 (77.8%) | |

**Graph 1 - Characterization of judicial outcome (n=372)**



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À minha mãe, pelo incansável apoio moral, pelas palavras de confiança e pela capacidade de me ensinar a acreditar que os sonhos podem tornar-se realidade.

Ao meu pai, pelo acompanhamento, o incentivo, a orientação e por ter despertado em mim o gosto pela aprendizagem e pela vontade de querer saber sempre mais.

À minha irmã Sofia, pelo encorajamento e pelo orgulho que tem em mim.

A toda a minha família, pelo carinho e pelas palavras de estímulo.

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Por último, um muito obrigado a todos aqueles que, mesmo não sendo mencionados aqui, me apoiaram e me deram força para que este trabalho seja uma realidade.

"O valor das coisas não está no tempo em que elas duram,

mas na intensidade com que acontecem.

Por isso existem momentos inesquecíveis,

coisas inexplicáveis e pessoas incomparáveis".

Fernando Pessoa

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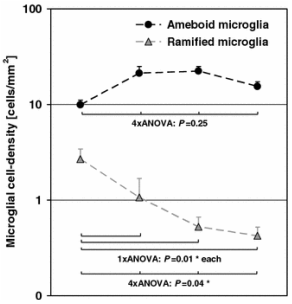


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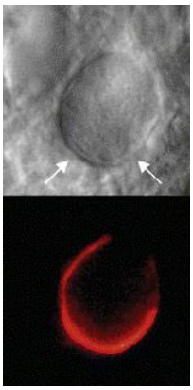

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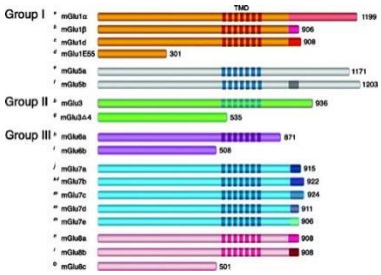


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